

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR-A15ME(5)  
6M 1-66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03071

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03058

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>8 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>216 Charles Street</u>		e. STREET ADDRESS <u>216 Charles Street</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Howard</u> Last <u>Alderton</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 1, 1913</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Food Market</u>		9b. AGE (In years last birthday) <u>52 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Food Market</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cecil Alderton</u>		14. MOTHER'S MAIDEN NAME <u>Bertie Troutman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-8864</u>	
17. INFORMANT <u>Mrs. Georgia Alderton</u>		Address <u>216 Charles St</u> <u>Cumberland, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 10, 1966</u>	
Address (Street, city, town, or county) <u>Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Gardens LaVale</u>	23d. LOCATION (City or Town) (County) (State) <u>Allegany Maryland</u>
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>	
ADDRESS <u>Cumberland Maryland 21502</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03084

03085

03086

CERTIFICATE OF DEATH

03072

03059

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			c. LENGTH OF STAY IN lb <b>36 HRS.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town); <b>R.F.D.1, FROSTBURG BOX 235</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS' HOSPITAL</b>				d. STREET ADDRESS <b>WOODLAND</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHERYL</b>		First <b>ANN</b> Middle <b>BAKER</b> Last		4. DATE OF DEATH <b>MARCH 13, 1966</b>		Month <b>13</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 12, 1966</b>	
9. AGE (In years last birthday) <b>13</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N.A.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FROSTBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EUGENE BAKER</b>				14. MOTHER'S MAIDEN NAME <b>MARY BITTINGER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>N.A.</b>		16. SOCIAL SECURITY NO. <b>N.A.</b>		17. INFORMANT <b>MR. EIGENE BAKER, R.F.D.1, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Prematurity</b> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>NONE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>✓</b>			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>✓</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>✓</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/12, 1966</b> to <b>3/13, 1966</b> that (I) (we) last saw the deceased alive on <b>3/13, 1966</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Martin M. Rothstein</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN, M.D.</b>				22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAR. 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. L. Lovers</b> ADDRESS <b>FROSTBURG, MD.</b>				25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03050

03050

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MAR 21 1966

U.S. DEPT. OF JUSTICE

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03073					03060				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>1602 HOLLAND ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>F.</b> Middle <b>GILLBERT</b> Last <b>BECKER</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 22, 1913</b>		9. AGE (In years last birthday) <b>52</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>			11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CASPER BECKER</b>					14. MOTHER'S MAIDEN NAME <b>ELMAR HOLLENBERGER</b>				
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>WW 2 214 05 4969</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Subarachnoid Hemorrhage due to spontaneous rupture of aneurysm of anterior communicating artery.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>330x</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>34 hours</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>March 14 4:12 P.M. 3-15-1966</b> , that (I) (we) last saw the deceased alive on <b>3-15-1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>DR. WYAND F. DOERNER JR.</b>					22b. DATE SIGNED <b>3-18-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. WYAND F. DOERNER JR.</b>					22d. ADDRESS <b>414 N. MECHANIC ST. CUMB. MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MARCH 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILIC CREST BURIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>		
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>					25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>				
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

03073

03080

ALLEGANY

ALLEGANY

BARB AND

CUMBERLAND

CUMBERLAND

1 DAY

MEMORIAL HOSPITAL

1502 HOLLAND ST

F.

GILBERT

BECKER

MARCH 12

MALE WHITE

JULY 22, 1913-22

CASPER BECKER

ELMAR HOLLENDER

MEMORIAL HOSPITAL

MAR 11 1956

DR. WYAND F. DOERNER JR. 414 N. MECHANIC ST. CUMB. MD.

4:12 P.M.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03074

## CERTIFICATE OF DEATH

03061

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE,</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>BOX323</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNAMARY CATHERINE BEVERS</b>		4. DATE OF DEATH Month Day Year <b>MARCH 26 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-91</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MT. SAVAGE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>THOMAS CARABINE</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA RAHRIG</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>218-07-8939</b>	
16. SOCIAL SECURITY NO. <b>218-07-8939</b>		17. INFORMANT <b>PATIENT'S CHART</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Tachycardia</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Myocardial Infarction</b> DUE TO (c) <b>ATHEROSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from causes on and on the date stated above.	
22a. SIGNATURE <b>L. Michael Glick</b> M.D.		22b. DATE SIGNED <b>27 Mar 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. MICHAEL GLICK, MD.</b>		22d. ADDRESS <b>126 N. SMALLWOOD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-29-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PATRICK'S CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>MT. SAVAGE, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.</b>		25a. REC'D BY REGISTRAR <b>FROSTBURG, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 31 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

13089

1552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03075 CERTIFICATE OF DEATH 03062									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>208 GRAND AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>IRVIN</b> Middle <b>C.</b> Last <b>BRANT</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 20, 1891</b>		9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber-Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>			11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THEODORE BRANK</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE BEECHE (Becky)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Artery Disease</b> DUE TO <b>Arteriosclerosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Days</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, Md.</b> 20f. (City or town) (County) (State) <b>Cumberland, Md.</b>									
21. I certify that (I) (this hospital) attended the deceased from <b>7/19/62</b> <b>7:05 P.M.</b> <b>3/19/66</b> 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>3/19/66</b> 19 <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>					22b. DATE SIGNED <b>3/20/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>					22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-22-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

03083

03073

ALL-ARMY

MEMORIAL HOSPITAL

CLINICAL AND

3-DAYS

CLINICAL AND

308 GRAND AVE.

MEMORIAL HOSPITAL

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MAY 20, 1921

MAY 20, 1921

U.S.A.

U.S.A.

CATHARTIC BECCE

NEEDLE OF DR.

MEMORIAL HOSPITAL

1921

122 S. CENTRE ST. CHICAGO, ILL.

DR. R. J. WILLIAMS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and they event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03076 CERTIFICATE OF DEATH					03063				
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>10/6/1964</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>					d. STREET ADDRESS <b>307 Walnut St.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ora</b>		First Middle Last <b>Edward Brinkman</b>		4. DATE OF DEATH <b>March 10, 1966</b>		Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/15/1892</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machine Foreman &amp; Paper, Luke</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>W. Va. Pulp</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Town Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry B. Brinkman</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Seaton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-09-3307</b>		17. INFORMANT <b>P.O. Box 599, Cumberland, Md</b> <b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> <i>Dependence Ch. degeneration</i> DUE TO (b) <i>Arterio Sclerosis &amp; Marked cerebral</i> (c) <i>deterioration &amp; cerebral apoplexy</i> <i>&amp; left heart lesion</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I (this hospital) attended the deceased from <b>10/6/1964</b> , 19___, to <b>3/10/66</b> , 19___, that I (we) last saw the deceased alive on <b>3/10/1966</b> , 19___, and that death occurred at <b>P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>Lee B. Mathews, M.D.</i>				at <b>10:10 P.M.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/11/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>			
24. FUNERAL DIRECTOR <i>Ed. Brul</i>				ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03003

03015

Allegany

Maryland

Allegany

West Virginia

10/10/1964

Chapman

Allegany County Jail

307 Main St.,

Robert

Prisoner

March 10,

73

10/12/1965

X

White

Male

Robertson, Thomas, Town Hall, Maryland, U.S.A.

Robertson, Thomas

Robertson, Thomas

Chapman

Allegany County Jail

3/10/66

10/10/64

3/10/66

at 10:10 P.M.

X 3/11/66

at 10:10 P.M.

at 10:10 P.M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>6-JANE FRAZIER VILLAGE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Cecelia</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>19 66</b>								
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-13-1885</b>		9. AGE (In years last birthday) <b>80</b> yrs. IF UNDER 1 Year IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>OHIO Belaire</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM TRAPP</b>					14. MOTHER'S MAIDEN NAME <b>MARY Tighe</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Disease</b> 4221 DUE TO (b) <b>Arteriosclerotic Cerebral Vascular Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus - Chronic</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 to <b>1966</b> , 19, that (I) (we) last saw the deceased alive on <b>3/23/66</b> , and that death occurred at <b>9:55 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. G. O. HIMMELWRIGHT</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/24/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>					22d. ADDRESS <b>133 VIRGINIA AVE.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>				
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>					25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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ALLEGANY

HARYLAND

ALLEGANY

CUMBERLAND

12 DAYS

CUMBERLAND

U-JANE PRATER VILLAGE

MENTAL HOSPITAL

WINTER

BROWN

FOOTER

MAW

9-12-1952

WHITE

UNIT

UNIT

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UNIT

MENTAL HOSPITAL, CUMBERLAND, MD.

UNIT

UNIT

103 VIRGINIA AVE.

DR. G. D. HILFELWRIGHT

UNIT

UNIT

MAR 2 8 1950

UNIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03078

03065

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN 1b <u>Cumberland,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>15 So. Centre St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Francis</u> Last <u>Cage</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1903</u>
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. Rwy.</u>	
11. BIRTHPLACE (State or foreign country) <u>Brunswick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Newton Cage</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Dyche</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Cora M. Cage</u>		Address <u>15 So. Centre St. Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio Sclerotic</u> DUE TO (c) <u>Ischemic Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>About 2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Grand Mal</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-27-1957</u> to <u>3-27-1966</u> , that I last saw the deceased alive on <u>1-6-1966</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>122 So. Centre St.</u>	
DATE SIGNED <u>3-28-66</u>			
PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Mar 30 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
5M 1/65

03079

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03066

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rawlings</b>			c. LENGTH OF STAY IN ID <b>Years</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital - DOA</b>			d. STREET ADDRESS <b>Cumberland, Maryland</b>		
3. NAME OF DECEASED (Type or print) First <b>Ivan</b> Middle <b>Lynn</b> Last <b>Campbell</b>			4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-1939</b>	9. AGE (In years last birthday) <b>26</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Oliver . Campbell</b>		
14. MOTHER'S MAIDEN NAME <b>Mary S. Cook</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1957-1958</b>		
16. SOCIAL SECURITY NO. <b>235-60-3064</b>			17. INFORMANT <b>Oliver Campbell</b> Address <b>Rawlings, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b> <b>8234</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Skull Fracture</b> DUE TO (c) <b>(Auto Accident--Driver)</b>					INTERVAL BETWEEN ONSET AND DEATH Minutes  Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Driver of automobile which struck tree</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>12:30</b> p.m. <b>March 11 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 220 2 Mile South Cresaptown, Alleg. Md.</b>	
20f. (City or town) (County) (State) <b>Allegany Co. Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <b>March 11, 1966</b>		23. ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		24. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
24b. DATE THEREOF <b>13 Mar 1966</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Waxler</b>		24d. LOCATION (City, town or county) (State) <b>Allegany Co. Md.</b>	
24e. FUNERAL DIRECTOR <b>Allen M. Rotunck</b>		ADDRESS <b>KEYSER, W.VA.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 14 1966</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03080

03067

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>MAIN ST.</b>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH E. CAMPBELL</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APR. 28th, 1903</b>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TICKET SELLER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RACING COMMISSION</b>		9. AGE (in years last birthday) <b>62 YRS.</b> IF UNDER 1 YEAR: Months <b>25</b> Days <b>15</b> Hours <b>56</b> Mln.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>MATTHEW CAMPBELL</b>				14. MOTHER'S MAIDEN NAME <b>SARAH CONROY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>213-01-4660</b>		17. INFORMANT <b>MRS. MARGARET G. CAMPBELL</b>		Address <b>MAIN STREET, MT. SAVAGE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO (b) <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 25, 1966</b>			
EXAMINER'S NAME (Type) <b>R. BENEDICT SKITARELLIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PATRICK'S CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MT. SAVAGE, MD.</b>	
24. FUNERAL DIRECTOR <b>Joseph R. Durst, Sr.</b>				ADDRESS <b>Frostburg, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5060

4202

2005-07-27

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03081

03068

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 F Jane Frazier Village</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Clelland</b> Last <b>Charlton</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	9. AGE (In years last birthday) yrs. <b>68</b>
11. BIRTHPLACE (State or foreign country) <b>Moorefield, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur A. Charlton</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Boswell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Beulah Corbett, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CORONARY SCLEROSIS</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>----</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>March 19, 1966</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 23, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oliver Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>		23e. REC'D BY REGISTRAR <b>MAR 22 1966</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03008

03008





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03069

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>66 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Maryland</b>		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital D.O.A.</b>				d. STREET ADDRESS <b>930 Glenwood St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Smith Clegget</b>				4. DATE OF DEATH Month Day Year <b>March 31 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 17, 1899</b>		9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours <b>24 HRS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman Garbage Collection Sanitation</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sanitation</b>		11. BIRTHPLACE (State or foreign country) <b>Allegany Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Clegget</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Clegget</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Maude Clegget</b> Address <b>930 Glenwood St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DATE SIGNED <b>March 31, 1966</b>		CITY AND COUNTY <b>Cumberland, Md.</b>		STATE <b>Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>				25a. REC'D BY REGISTRAR <b>APR 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided for the signature of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 4 1955

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03083		Item 3 Film 0375		4/13/66		03070			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>					d. STREET ADDRESS <b>Scotch Hill</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HUGH</b>		First <b>WILSON</b>		Last <b>COOK, Jr.</b>		4. DATE OF DEATH Month <b>3/9/1966</b> Day <b>19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug, 30th. 1921</b>		9. AGE (In years last birthday) <b>44 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pittsburgh Plate Glass CO.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing</b>		11. BIRTHPLACE (State or foreign country) <b>USA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
13. FATHER'S NAME <b>Hugh Cook</b>					14. MOTHER'S MAIDEN NAME <b>Bessie Hutcheson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>War # 2 219-03-8984</b>		17. INFORMANT Address <b>Mrs. Marcene Cook, Lonaconing, MD.</b> <b>(WIFE)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION WITH THROMBOSIS</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROSIS OF CORONARY</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Lonaconing</b>		20g. (County) <b>Allegany</b>	
20h. (State) <b>Md.</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>		Cumberland, MD.		city, town, or county		DATE SIGNED <b>3/9/1966</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. View Cemetery</b>		22d. LOCATION (City, town, or country) <b>Moscow, MD.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>					ADDRESS <b>Lonaconing, MD.</b>				
24a. REC'D BY REGISTRAR <b>MAR 14 1966</b>					24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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## CERTIFICATE OF DEATH

03071

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>959 National Hwy. LaVale</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edgar</b> Last <b>Crites</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-1894</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (County & State, or foreign country) <b>W. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Crites</b>	
14. MOTHER'S MAIDEN NAME <b>Rose May Crites</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW 1</b>	
16. SOCIAL SECURITY NO. <b>232 18 3664</b>		17. INFORMANT <b>Patient's Chart</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Thrombocytosis</b> DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>20 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-4</b> , 19 <b>66</b> to <b>3-22</b> , 19 <b>66</b> that (I) <del>was</del> last saw the deceased alive on <b>3-22</b> , 19 <b>66</b> , and that death occurred at <b>1P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>L. Michael Glick</b>		22b. DATE SIGNED <b>3-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Michael Glick</b>		22d. ADDRESS <b>126 N. Smallwood St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MARCH 25, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER &amp; PAUL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03085

CERTIFICATE OF DEATH

03072

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>	
c. LENGTH OF STAY IN lb <b>65 Yrs</b>		d. STREET ADDRESS <b>233 Md. Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>233 Md. Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna</b> First Middle Last <b>Cross</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1880</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (County & State, or foreign country) <b>Lithuania</b>		14. CITIZEN OF WHAT COUNTRY? <b>Lithuania</b>	
15. FATHER'S NAME <b>Thomas Vivado</b>		16. MOTHER'S MAIDEN NAME <b>not known</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO.	
19. INFORMANT <b>Rose Cross-Westernport, Md.</b>		Address	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Interventricular septal aneurysm</b> (c) <b>Myocardial infarction</b> <b>5 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item IB.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>3-24</b> , 1966, that (I) <del>was</del> last saw the deceased alive on <b>3-20</b> 1966, and that death occurred at <b>3:00 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Bess</b>		22b. DATE SIGNED <b>3-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Bess</b>		22d. ADDRESS <b>Piedmont, W.Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/28/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>	23d. LOCATION (City or Town) (County) (State) <b>Westernport Md</b>
24. FUNERAL DIRECTOR <b>W. J. Bess</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judd</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03086

03073

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Memorial Hospital</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 3 Rawlings, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cumberland, Maryland</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Edward Crossland</b>		First Middle Last		4. DATE OF DEATH <b>March 5th 1966</b>		Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 13, 1917</b>		9. AGE (In years last birthday) <b>49</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		11. BIRTHPLACE (State or foreign country) <b>Grant Co., W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Crossland</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Flanagan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 10 7744</b>		17. INFORMANT <b>Elizabeth Jane Crossland</b> Address <b>Rt #3, Rawlings, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>8254</b> DUE TO <b>Crushed Skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>(Automobile Accident-Driver)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Driver of Automobile involved in accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of Automobile involved in accident</b>					
22c. TIME OF INJURY Hour <b>10:15</b> p.m. Month, Day, Year <b>March 5, 1966</b>		22d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 220--2 mile South, Rawlings, Alleg. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 5, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Maryland</b>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 9, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Waxler Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Rt #3, Rawlings, Md.</b>	
23. FUNERAL DIRECTOR <b>Allen M. Rotruck</b> ADDRESS <b>Keyser, W. Va.</b>				24a. REC'D BY REGISTRAR <b>MAR 7 1966</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03074

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>26 BEALL'S LANE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>26 BEALL'S LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>GRANT</b> Last <b>DURST</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 13, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MORTON'S GARAGE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>HUDSON DURST</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-05-4423</b>	
17. INFORMANT <b>JOHN C. DURST, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> <b>4201</b> DUE TO (b) <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>3/5/66</b>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>RD 9,</b>	
		Address (Street, city, town, or county) <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAR. 8 '66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FB'G. MEMORIAL PARK</b>	23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 9 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03074

UNITED STATES DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1961

STATE OF

Form with multiple sections for medical examination, including fields for patient information, medical history, and examiner's findings. The form is mostly blank with some faint markings and a circular stamp on the left side.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
DR. JACOBSON					03075					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT,</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>421 WALNUT STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>LUTHER</b>		First <b>O.</b> Middle <b>EVANS</b>		Last <b>EVANS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-8-1885</b>		9. AGE (in years last birthday) <b>80</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MINER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID EVANS</b>					14. MOTHER'S MAIDEN NAME <b>ARMEDA KESSEL</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Aricular Fibrillation</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5230 <b>Silicosis</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1966</b> to <b>March 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar. 24, 1966</b> , and that death occurred at <b>3:10 AM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <i>Samuel M. Jacobson</i>					22b. DATE SIGNED <b>Mar. 26, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. SAMUEL M. JACOBSON</b>			
22d. ADDRESS <b>50 PERSHING STREET, CUMBERLAND, MD.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>				
24. FUNERAL DIRECTOR <i>Ed. Bral</i>					ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 29 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03075

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ARMED HESSEL

DAVID EVANS

MEMORIAL HOSPITAL - CLINGMAN, MD.

CLINGMAN, MD.

ON PENDING STREET, CLINGMAN, MD.

DR. SAMUEL H. LINDEN

CLINGMAN, MD.

CLINGMAN, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03089					03076				
Item 2 Film 6575 4/21/66 mh									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dawson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dawson Barton</b> 01-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Van Pelt Nursing Home</b>					d. STREET ADDRESS <b>Railroad St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Brill</b> Last <b>Fazenbaker</b>					4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 21, 1907</b>		9. AGE (In years last birthday) <b>58</b> yrs. IF UNDER 1 YEAR: Months <b>10</b> Days <b>17</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired House Wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Zepp, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Brill</b>					14. MOTHER'S MAIDEN NAME <b>Rose Miller</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Robert L. Brill</b>			Address <b>Keyser, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Chronic pyelonephritis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>ten years</b> <b>years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>December, 1961</b> , to <b>March 5, 1966</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>6:15 p.m.</b> from <b>the</b> causes and on the date stated above.									
22a. SIGNATURE <b>Phillip G. Staggers</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>3-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Phillip G. Staggers</b>					22d. ADDRESS <b>Keyser, W. Va.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Keyser, W. Va.</b>		
24. FUNERAL DIRECTOR <b>Thomas Smith Jr.</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
ADDRESS <b>Keyser, W. Va.</b>					DATE <b>MAR 10 1966</b>				

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03090

03077

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>21 Years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>17 Decatur St.</u>				d. STREET ADDRESS <u>17 Decatur St.</u>			
3. NAME OF DECEASED (Type or print) <u>George A. Flynn</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 19, 1909</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harrison, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Justin P. Flynn</u>				14. MOTHER'S MAIDEN NAME <u>Caroline (Gabbert) Flynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>234-10-6249</u>			
17. INFORMANT <u>Mrs. Beatrice Flynn</u>				Address <u>17 Decatur St., Cumb. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							
DUE TO (b) <u>Myocardial Infarction, recent</u>							
DUE TO (c) <u>Coronary Heart Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lactory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1959</u> to <u>March 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1966</u> , and that death occurred at <u>5:30 AM</u> the causes and on the date stated above.							
22a. SIGNATURE <u>James P. Hallinan</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-8-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. James P. Hallinan</u>				22d. ADDRESS <u>140 Bedford St., Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 9, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 11 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
03091					CERTIFICATE OF DEATH					03078					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>76 W. MECHANIC ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>B.</b> Last <b>FOLK</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>1966</b>										
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 4, 1884</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>THOMAS J. THOMAS</b>						14. MOTHER'S MAIDEN NAME <b>CLARA M. WADE</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>CHAS. E. FOLK, FROSTBURG, MD.</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior clove the Cardiovascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Huge Uterine Fibroid - Acute</b>												INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>6 MARCH, 1966</b> , to <b>11 MARCH, 1966</b> , that (I) (we) last saw the deceased alive on <b>11 MARCH 1966</b> , and that death occurred at <b>9AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Martin M. Rothstein</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/13/66</b>							
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN, M. D.</b>						22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>MAR. 14 '66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FB'G. MEMORIAL PARK</b>				23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>						25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

03078

CENTRAL STATE OF TEXAS

03081



1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03092

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03079

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>Route 2, Williams Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Denzil</b> Middle <b>H.</b> Last <b>Friend</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 66</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 26, 1914</b>		9. AGE (In years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR: Months <b>01</b> Days <b>1</b> IF UNDER 24 HRS.: Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Swanton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry W. Friend</b>				14. MOTHER'S MAIDEN NAME <b>Maggie R. xrode</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Hazel P. Leslie, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>LOBAR PNEUMONIA, BILATERAL</b> 490X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>MARCH 1, 1966</b> Cumberland, Md. Address (Street, city, town, or county)							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>		22. DATE SIGNED					
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Swanton, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

05070

05088

MEDICAL EXAMINER CERTIFICATE OF DEATH

Albany

Albany Hospital

Female

Albany

Albany

Albany

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03093 CERTIFICATE OF DEATH 03080									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Corrigansville, Md.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kyle Nursing Home</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <u>Catherine</u> Middle <u>Nickle</u> Last <u>Geiger</u>		4. DATE OF DEATH		Month <u>March</u> Day <u>9</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>01</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>01</u> Min. <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Allegany Co., Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Nickle</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Oklen H. Geiger</u>		Address <u>Corrigansville, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic C V disease</u> DUE TO (c) <u>Arteriosclerotic gangrene left leg</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic gangrene left leg</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>3-9</u> , 1966, that (I) (we) last saw the deceased alive on <u>3-8</u> 1966, and that death occurred at <u>8p</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>L.R. Miles, Jr.</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-11-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR., M.D.</u>					22d. ADDRESS <u>LONA CONING MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Land Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cash Valley Rd. Md</u>			
24. FUNERAL DIRECTOR <u>Harvey H. Zeigler</u>					ADDRESS <u>Hyndman, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03080

RECEIVED

03080



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03094

Item 3 Film G375 4/20/66 mh

CERTIFICATE OF DEATH

03081

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport rural</b>		c. LENGTH OF STAY IN lb <b>40 Yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westernport</b>		61-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Lewis Garland Garland / Lewis Grove</b>		4. DATE OF DEATH <b>Mar. 11 1966</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>May 14, 1897</b>	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) yrs. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Garrett-Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James L Grove</b>		14. MOTHER'S MAIDEN NAME <b>Lavina Fazebaker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. 1</b>		16. SOCIAL SECURITY NO. <b>217-10-7964</b>	
17. INFORMANT <b>Mrs. Mary Grove</b>		Address <b>Westernport, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1966</b> , to <b>Mar. 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1966</b> , and that death occurred at <b>8:28 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson</b>		22b. DATE SIGNED <b>Mar. 11, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>		22d. ADDRESS <b>Piedmont, W.Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR <b>E. J. B...</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>	
ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03095

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03082

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>8HRS 15 MIN</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>10 EAST CLEMENT ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MITCHELL</b>		First <b>ROY</b>		Middle <b>HANSON</b>		Last <b>HANSON</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 21, 1911</b>		9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemical Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY Interfall, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>XXXXXXXXXX</b>				14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXXXXXXXXXXXX</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no, or unknown) (If yes give war or dates of service) <b>yes War 11</b>		16. SOCIAL SECURITY NO. <b>220-09-2327</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3561 Lateral Sclerosis of spine</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive Cerebral Haemorrhage Acute</b> (c)										INTERVAL BETWEEN ONSET AND DEATH <b>June 1965</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15, 66 9:25 to P.M. 3/22/1966</b> that (I) (we) last saw the deceased alive on <b>Mar. 22 19 66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Clayton E. Durrett</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>3/23/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>				22d. ADDRESS <b>236 VIRGINIA AVE. CUMBERLAND, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-25-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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ALLEGANY

MARYLAND

2802 15 MIN. CUMBERLAND

CUMBERLAND

MEMORIAL HOSPITAL

15 EAST CLEMENT ST.

MARCH 22

HANSON

ROY

MITCHELL

DEC. 21, 1911

MALE WHITE

MEMORIAL HOSPITAL

DEC. 21, 1911

DR. CLAY E. DURRETT

256 VICTORIA AVE. CUMBERLAND

MAR 23 1966

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

03096

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03083

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROUTE 1, FROSTBURG</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>S.</b> Last <b>HARVEY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 6, 1892</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT HARVEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY GIBSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>336-34-4639</b>		16. SOCIAL SECURITY NO. <b>MRS. MAGGIE HARVEY, FROSTBURG, MD.</b>	
17. INFORMANT <b>BOX 131, RT. 1,</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO (b) <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED <b>3/23/66</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M. D.</b>		Address (Street, city, town, or county) <b>RD 9, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-25-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FB'G. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 will be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03084

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY in 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hosp. DOA</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> d. STREET ADDRESS <u>1607 Bedford St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julius</u> First Middle Last 4. DATE OF DEATH <u>March 23 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 7 1889</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Spoerls' Garage</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Host</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mrs. Julius Host</u> Address <u>Cumberland Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO (b) <u>Arterio Scl. C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumby Alley Md</u> 20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/3/66</u> , 19 <u>66</u> , to <u>3/23/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/10/66</u> , 19 <u>66</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Williams</u> 22c. PHYSICIAN'S NAME (Type) <u>R.D. Williams</u> 22d. ADDRESS <u>Cumberland Md</u>		22b. DATE SIGNED <u>3/25/66</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/26/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. - Cum. Md.</u> ADDRESS <u>—</u> 25a. REC'D BY REGISTRAR <u>MAR 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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03084



MAR 28 1966

Handwritten text at the bottom of the page, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03098						CERTIFICATE OF DEATH						03085	
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>16 months</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						01-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sylvan Retreat</b>						d. STREET ADDRESS <b>621 N. Mechanic Street</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Helker</b> Last <b>Helker</b>						4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 66</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1885</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Construction Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Worker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allegany County Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henry Helker</b>						14. MOTHER'S MAIDEN NAME <b>Mary Ahouse</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-05-9588</b>		17. INFORMANT <b>John L. Helker</b>		Address <b>621 N. Mechanic St Cumberland, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Myocarditis, chr. degenerative</b> <b>4221</b> DUE TO <b>② Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>③ Gangrene left foot, due to</b> DUE TO <b>④ Circulatory changes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b></b>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5, 1964</b> to <b>March 23, 1966</b> that (I) (we) last saw the deceased alive on <b>March 23, 1966</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>L. B. Mathews</b>						M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>L. B. Mathews, M.D.</b>						22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Alleg Co Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>						ADDRESS <b>Cumberland Maryland 21502</b>		25. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03088

CERTIFICATE OF DEATH

03088

*[Faint, illegible text and markings on a form, possibly a death certificate. The text is mirrored across the page, suggesting a bleed-through from the reverse side. Some faint words like "CERTIFICATE OF DEATH" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03099 04607									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>35 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>34 Browning Street</u>					d. STREET ADDRESS <u>34 Browning Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Clayton</u> Last <u>Herring</u>			4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1966</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1889</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Savage, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John C. Herring</u>					14. MOTHER'S MAIDEN NAME <u>Mary C. Hergot</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Wm. Cassell, Cumberland, Md. - Daughter</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Pulmonary Embolus</u> DUE TO <u>ryn</u> (c) <u>ryn</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>3</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1965</u> to <u>Mar 31, 1966</u> , that (I) (we) last saw the deceased alive on <u>Mar 31, 1966</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles E. Durrett</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/3/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Clay E. Durrett, M.D.</u>					22d. ADDRESS <u>236 Virginia Ave. Cumberland, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>April 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. George Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Mt. Savage, Md.</u>		
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>					ADDRESS		25a. REC'D BY REGISTRAR <u>APR 12 1966</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

100290

100290

100290



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03100

03086

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>5 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Curtis Leroy Hickie</u>				4. DATE OF DEATH Month Day Year <u>March 27, 1966</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1920</u>		9. AGE (In years last birthday) yrs. <u>45</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper Advertising</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George D. Hickie</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Burley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW2 214-05-5569</u>		17. INFORMANT Address <u>Mrs. Betty Hickie, Ellerslie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angiopathic Latent Sclerosis</u> <u>3561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> 19 <u>66</u> , to <u>3-27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-14</u> 19 <u>66</u> , and that death occurred at <u>2:25</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William P. James</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William P. James, M.D.</u>				22d. ADDRESS <u>441 N. Centre St., Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lybarger Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Buffalo Mills, Pa. RD #1</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler</u>				ADDRESS <u>Hyndman, Pa.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1 (M)  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03101

03087

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHIMBERLAND</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural Frostburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Robert</b> Last <b>Howard</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>15</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1906</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>59</b> Days <b>15</b> Hours <b>15</b> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>			11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Garland Howard</b>				14. MOTHER'S MAIDEN NAME <b>Martha O'Neil</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-03-4262</b>		17. INFORMANT Address <b>Mrs. Doris Howard-Rd. 1-Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>8259</b> DUE TO <b>Hemothorax</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Fractured Ribs</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of Vehicle involved in accident</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:05</b> a.m. <b>3/15/66</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 36</b>		20f. (City or town) (County) (State) <b>Gilmore Allegany Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				22. DATE SIGNED <b>3/15/66</b>			
EXAMINER'S NAME (Type) <b>DR. BENEDICT SKITARELIC, M.D.</b>				22. DATE SIGNED <b>3/15/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bloomington</b>		23d. LOCATION (City, town or county) (State) <b>Bloomington Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Westernport, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08081

0310

MEMORANDUM FOR THE RECORD

Subject: [illegible]

Source: [illegible]

Classification: [illegible]

Date: [illegible]

Page: [illegible]

Reference: [illegible]

James Earl Ray

1. This document is a copy of a letterhead memorandum (LHM) dated 11/11/68, from the [illegible] to the [illegible].

2. The LHM is classified as [illegible].

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

James Earl Ray

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03102

CERTIFICATE OF DEATH

04614

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				c. LENGTH OF STAY IN lb <b>5 HOURS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS' HOSPITAL</b>				d. STREET ADDRESS <b>BIG SAVAGE MOUNTAIN</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BABY BOY IMES</b>				4. DATE OF DEATH Month Day Year <b>MARCH 25, 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 25, 1966</b>	
9. AGE (In years last birthday) yrs. Months Days <b>5</b>		10. IF UNDER 1 YEAR Months Days <b>5</b>		11. IF UNDER 24 HRS. Hours Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N.A.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N.A.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FROSTBURG, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>EUGENE CUTTER</b>				14. MOTHER'S MAIDEN NAME <b>SALLY ANN IMES (UNMARRIED)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>N.A.</b>				16. SOCIAL SECURITY NO. <b>N.A.</b>			
17. INFORMANT Address <b>FROSTBURG, MD.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - due to premature labor</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>✓ 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/25, 1966</b> to <b>3/25, 1966</b> that (I) (we) last saw the deceased alive on <b>3/25, 1966</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Martin M. Rothstein</i> M.D.				22b. DATE SIGNED <b>4/12/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN, M.D.</b>				22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAR. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MC KENZIE CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>GARRETT COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harley M. Suess</i> <b>HAER FUNERAL HOME, 60 W. MAIN ST.</b>				25. REC'D BY REGISTRAR <b>APR 19 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6-224378

03103

03014

(C)

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CERTIFICATE OF DEATH

03103

03088

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			c. LENGTH OF STAY in lb <b>1 DAY</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS' HOSPITAL</b>				d. STREET ADDRESS <b>79 HILL STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>IRWIN</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 23, 1891</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>01</b> Min. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRIENDSVILLE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN MYERS</b>				14. MOTHER'S MAIDEN NAME <b>MONTERA BARNHOUSE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. ANDREW LASLO</b>	
				Address <b>FROSTBURG, MD.</b>		<b>85 HILL STREET</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>4331</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Auricular Fibrillation</b> (c) <b>24 hrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Poss. Carcinoma of head of Pancreas</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 20, 1966</b> to <b>March 25, 1966</b> , that (I) <del>last</del> saw the deceased alive on <b>March 25, 1966</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis</b> , M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, M.D.</b>				22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAR. 28, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HAFFER FUNERAL HOME, 60 W. MAIN ST.</b>				25. REC'D BY REGISTRAR <b>APR 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03104					03089				
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>9/10/60</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>					d. STREET ADDRESS <b>460 Footer Place</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <b>Margaret</b> Middle <b>Adele</b> Last <b>Johnson</b>			4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12/13/1889</b>		9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>William Henry Gladhill</b>					14. MOTHER'S MAIDEN NAME <b>Susan Rebecca Sock</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>217-14-4549</b>		17. INFORMANT <b>P.O.Box 599 Cumberland, Md.</b> <b>Allegany County Infirmary Records.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2002 Myocarditis etc. degenerating to acute decompensation &amp; Arteriosclerosis</b> DUE TO <b>(b) Bilateral cataracts</b> DUE TO <b>(c) Malignant Lymphoma to second metastasis</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from <b>9/10/60</b> , 19 <b>60</b> , to <b>3/13/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/12/66</b> , and that he died at <b>8:25 A.M.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Lee B. Mathews</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>3/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WAYNESBORO, PA.</b>			
24. FUNERAL DIRECTOR <b>POE FUNERAL HOME</b>				ADDRESS <b>WAYNESBORO, PA.</b>		25a. REC'D BY REGISTRAR <b>MAR 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03105					03090				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			d. STREET ADDRESS <b>622 SHRIVER AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			
First Middle Last <b>WALLACE -- JOHNSON</b>			Month Day Year <b>MARCH 27 19 66</b>			<b>M</b>			
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/4/02</b>		9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchandising Mgr.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Henry H. JOHNSON</b>					14. MOTHER'S MAIDEN NAME <b>Frances Johnson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-4202</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lungs</b> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>Fast diagnosed Aug. '65</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8-31-1965</b> to <b>3-27-1966</b> , that (I) (we) last saw the deceased alive on <b>3-27-1966</b> , and that death occurred at <b>10:51 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>W.F. Williams</b>					22b. DATE SIGNED <b>3-28-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>					22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>					25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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121-6-1202 RM MEMORIAL HOSPITAL, CUMBERLAND, MD.



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121-6-1202 RM MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. W.F. WILLIAMS

MAR 27 1958



FOR STATE HEALTH DEPT.

03106

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03091

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>20 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>513 Henderson Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Leroy</b> Last <b>Keiley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1945</b>
9. AGE (In years lost birthday) yrs. <b>20</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Active Duty-U. S. Marine Corp. Reserve</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Keiley</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Lechlitter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes U.S.M. Reserve</b>		16. SOCIAL SECURITY NO. <b>Mr. James E. Keiley, Cumberland, Md.</b>	
17. INFORMANT <b>Mr. James E. Keiley, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>976 X</b> IMMEDIATE CAUSE (a) <b>SHOCK, IRREVERSIBLE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ABDOMINAL HEMORRHAGE</b> DUE TO <b>GUNSHOT OF ABDOMEN (SELF INFLICTED)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 Hours</b> <b>5 1/2 Hours</b> <b>5 1/2 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>March 2, 1966 Cumberland, Md.</b>	
22. DATE SIGNED <b>March 2, 1966 Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 5, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03107					03092						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY			ALLEGANY		a. STATE			MARYLAND			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			CUMBERLAND		b. COUNTY			ALLEGANY			
c. LENGTH OF STAY IN			18 HOURS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			NIKEP			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEMORIAL HOSPITAL											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			WILLIAM		C.		KIDDY		MARCH 8, 19 66		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-12-1911		54 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer								LONA CONING, MD.		U. S. A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
ROBERT KIDDY					LOTTIE LEE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
(Yes, no, or unknown)			(If yes give war or dates of service)		220-03-7059		MEMORIAL HOSPITAL - CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										260X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO	
										(b)	
										DUE TO	
										(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		5/7, 19 66		3/8, 19 66		
21. I certify that (I) (this hospital) attended the deceased from 5/7, 19 66 to 3/8, 19 66, that (I) (we) last saw the deceased alive on 3/8 19 66, and that death occurred at 9:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
DR. S. G. WEISMAN										3/10/66	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
DR. S. G. WEISMAN					59 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			3/11/66		Laurel Hill Cemetery			Moscow, Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George Eichhorn					Lonaconing, Md.		MAR 14 1966		Charles Judge		

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MEMORIAL HOSPITAL

MARCH 6

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12-12-1941

WHITE

NAME

U. S. A.

LOVACONING, MT.

LOTIE LEE

ROBERT KIDNEY

350-02-305 MEMORIAL HOSPITAL - CONDELLAND, MT.

03101

DR. E. A. WEISSMAN 30 GREEN ST., CONDELLAND, MT.

DR. E. A. WEISSMAN

in

1941

State of West Virginia

3/6/41

Page 2

LOVACONING, MT.

ALLEGANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03108									
03093									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>103 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>RT.#4, OLDTOWN RD.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>FRANCES</b> Last <b>KIPE</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>1966</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 24, 1928</b>		9. AGE (in years last birthday) <b>37</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appliance Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ALBERT THEODORE RICE</b>					14. MOTHER'S MAIDEN NAME <b>ROSE MARY MAFFLEY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced Ca of ex c</b> <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>widespread metastases</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>NOV. 24, 1965</b> to <b>MARCH 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>MARCH 7, 1966</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.								22b. DATE SIGNED	
22a. SIGNATURE <b>A. J. Mirkin</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <b>115 S. CENTRE ST. CUMB. MD.</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. A.J. MIRKIN</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 10, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

08003

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

103 DAYS

CUMBERLAND

ST. R. CLINTON RD.

MEMORIAL HOSPITAL

1922

MAY 25

RIPE

FRANCE

ANNA

MAY 25, 1928

FEMALE WHITE

U.S.A.

CUMBERLAND, MD.

BASE MARY WARELY

ALBERT THEODORE ELLIS

MEMORIAL HOSPITAL

112 S. CENTRE ST. CUMBERLAND, MD.

DR. T. J. WERKIN



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03109

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03094

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD 4, Oldtown Road</b>		d. STREET ADDRESS <b>RFD 4, Oldtown Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Wesley</b> Middle <b>James</b> Last <b>Kipe, Sr.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1891-75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (In years last birthday) <b>75</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Knoxville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Kipe</b>		14. MOTHER'S MAIDEN NAME <b>Etta Campbell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War K</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Raymond Kipe, Cumberland, Md.-Son</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYDROTHORAX, PULMONARY EDEMA</b> 1621 DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>BRONCHOGENIC CARCINOMA</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 20, 1966</b>	
		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 23, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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*Handwritten signature*

03110

## CERTIFICATE OF DEATH

03095

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>14 HRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. STREET ADDRESS <b>800 COLUMBIA AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>ELIZABETH</b> Last <b>KIRK</b>		4. DATE OF DEATH Month <b>3</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/92</b>
9. AGE (In years, lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Smith</b>		14. MOTHER'S MAIDEN NAME <b>Rose Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Maurice Kirk</b>		Address <b>800 Columbia Ave Cumb. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>7 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3 - 23</b> , 19 <b>66</b> , to <b>3 - 24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3 - 23</b> , 19 <b>66</b> , and that death occurred at <b>4</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. R. Ballin</b>		22b. DATE SIGNED <b>3-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. BALLIN</b>		22d. ADDRESS <b>62 Greene St. Cumberland, Md 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/26/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD</b> d. STREET ADDRESS <b>615 PATTERSON AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>WILLIAM G. KOLB</b>			First <b>G.</b>		Middle <b>KOLB</b>		Last <b>KOLB</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 28, 1883</b>		9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>28</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tool Operator Tool Co</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Tool Co</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE KOLB</b>					14. MOTHER'S MAIDEN NAME <b>EMMA CASTLE</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 526X IMMEDIATE CAUSE (a) <b>Bronchitis</b> DUE TO <b>Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Acute pulmonary emphysema</b> DUE TO (b) <b>Emphysema</b> (c) <b>Acute pulmonary emphysema</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>1 week</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>10:15 P.M. 3/9, 1966</b> , that (I) (we) last saw the deceased alive on <b>3/9, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>S. G. Weisman</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/10/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. S.G. WEISMAN</b>					22d. ADDRESS <b>59 GREENE ST. CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Manor Ph</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>			
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>					ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

02030

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

5 DAYS

CUMBERLAND

615 PATTERSON AVE.

MEMORIAL HOSPITAL

APR 28 1983

KNOW

WILLIAM D.

MALE WHITE

AUG. 28, 1883

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CUMBERLAND, MD.

EMMA CASTLE

GEORGE KID

MEMORIAL HOSPITAL

10:15 P.M.

DR. S. E. WEISMAN

XX 20 GREENE ST. CUMBERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03112 Item 8 Film 0374 5/21/66 mb											
CERTIFICATE OF DEATH 05097											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>418 Fayette Street</b>					d. STREET ADDRESS <b>418 Fayette Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>B.</b> Last <b>La Manca</b>			4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 66</b>								
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1888</b> <b>Sept. 11, 1887</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consultant &amp; Linguist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Government-Private</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rotondella, Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Paul F. La Manca</b>					14. MOTHER'S MAIDEN NAME <b>Carmela Marie Mazzei</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Mrs. Irene La Manca, Cumberland, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of larynx</b> <b>161X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <b></b> DUE TO (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>6 - 1</b> , 19 <b>65</b> to <b>3 - 13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3 - 13</b> , 19 <b>66</b> , and that death occurred at <b>7p</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Ralph W. Ballin</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-15-1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ralph W. Ballin, M.D.</b>					22d. ADDRESS <b>62 Greene St., Cumberland, Md. 21502</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 18 1966</b>					25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Since 7/3/64</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kinch Nursing Home</b>		d. STREET ADDRESS <b>Somerset</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Idella</b> Last <b>Landis</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 15, 1877</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>11</b> Hours <b>19</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Somerset Co. Pennsylvania</b>	
12. FATHER'S NAME <b>William Foust</b>		13. MOTHER'S MAIDEN NAME <b>Rebecca Brant</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		15. SOCIAL SECURITY NO. <b>Emmons Landis, Hazen Rd. Route 2, Cumberland Md</b>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> Conditions, if any, which gave rise to immediate cause (b) <b>myocardial infarction</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>6 min</b> <b>5 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
18a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	18b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	18d. (City or town) (County) (State)
19. I certify that (I) (this hospital) attended the deceased from <b>Jan. 10, 1966</b> to <b>Mar. 11, 1966</b> that (I) (we) last saw the deceased alive on <b>Mar. 10, 1966</b> and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.			
20a. SIGNATURE <b>Clayton L. Lurrett</b>		20b. DATE SIGNED <b>Mar. 11, 1966</b>	
21c. PHYSICIAN'S NAME (Type)		21d. ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 13, 1966</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ridge Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Near Garrett, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafler</b>		23b. ADDRESS <b>230 Balto Ave., Cumberland, Md</b>	
24a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF TEXAS

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County of \_\_\_\_\_ State of \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03114					03099				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>6 HRS. 35 MIN</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>600 LOUISIANA AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b>			Middle <b>A.</b>		Last <b>LANHAM</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>19 66</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 10, 1907</b>		9. AGE (In years last birthday) <b>59</b> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HAHN</b>					14. MOTHER'S MAIDEN NAME <b>HATTIE PARSONS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>277-22-4924</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>6 hrs.</b> <b>??</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial fibrosis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3-12-66</b> , <b>2:50 P.M.</b> <b>3/12</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/12/66</b> , and that death occurred at <b>11</b> M., from the causes and on the date stated above.									
22a. SIGNATURE <i>Samuel M. Jacobson</i>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. SAMUEL M. JACOBSON</b>					22d. ADDRESS <b>50 PERSHING ST. CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Marc. 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Standing Rock Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Kent, Ohio</b>		
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAR 17 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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CUMBERLAND

800 LOUISIANA AVE.

MEMORIAL HOSPITAL

MARCH 12

LAMHAN

MARGARET

MARCH 10, 1907

WHITE

U.S.A.

WEST VIRGINIA

HATTIE BARBONS

WILLIAM HAIN

MEMORIAL HOSPITAL

DR. SAMUEL M. JACOBSON 20 PESSHINE ST. CUMBERLAND, MD.

DR. SAMUEL M. JACOBSON

MAR 11 1908



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03115					03100						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Allegany</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>						
c. LENGTH OF STAY IN 1b <b>15 years</b>					d. STREET ADDRESS <b>419 Springdale Street</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>419 Springdale Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First <b>Thomas</b>		Middle <b>Wesley</b>		Last <b>Lease</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 66</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1894</b>		9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>01</b> Days <b>1</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rawlings, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Jacob Lease</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Huff</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>					16. SOCIAL SECURITY NO. <b>217-10-9382</b>		17. INFORMANT <b>Mrs. Barbara Lease, Cumberland, Md. Wife</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Coronary Thrombosis</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis &amp; Deformation</b> DUE TO (c) <b>Atherosclerosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 5 mos</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> , to <b>Mar 10, 1966</b> that (I) (we) last saw the deceased alive on <b>Mar 4, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Clay E. Durrett</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 11, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, M.D.</b>					22d. ADDRESS <b>236 Virginia Ave., Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 13, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>				
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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MAR 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
20M 1/65

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03116					03101				
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND,					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE E. LEE					4. DATE OF DEATH Month Day Year MARCH 5 1966				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 27, 1902		9. AGE (in years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY JOHNSON					14. MOTHER'S MAIEN NAME ANN DILLMAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the colon</i> 1531 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>The coiled Carcinoma transverse colon</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART 1(a)								INTERVAL BETWEEN ONSET AND DEATH 6 months 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1964 to Mar 5, 1966, that (I) (we) last saw the deceased alive on Mar 4 1966, and that death occurred at 4:45 PM, from the causes and on the date stated above.									
22a. SIGNATURE <i>DR. DONALD B. GROVE</i>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE								22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/66		23c. NAME OF CEMETERY OR CREMATORY George Cem.		23d. LOCATION (City, town or county) (State) Swanton Md.			
24. FUNERAL DIRECTOR <i>E. J. B. B. B.</i> Westernport, Md.						25a. REC'D BY REGISTRAR MAR 10 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

05101

05118

ALLEGANY

MARYLAND

ALLEGANY

CREIGHTON

25 DAYS

CHIEFLAND

MEMORIAL HOSPITAL

MARCH 2, 1900

LEE

BLANCHE E.

23

NOV. 27, 1902

FEMALE, WHITE

U.S.A.

MARYLAND

JOHN DILLMAN

HENRY JOHNSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

122 SOUTH CENTRE ST., CUMBERLAND

DR. DONALD B. GROVE

George C.

George C.

Westport, Md.

George C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03117 CERTIFICATE OF DEATH 03102									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>3/14/64</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Flintstone</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>					d. STREET ADDRESS <b>Route #2</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>Loring</b> Last <b>Littlefield</b>					4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/26/1889</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Farmer &amp;</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Textile Worker-Celanese Corp. James Littlefield</b>					14. MOTHER'S MAIDEN NAME <b>Hannah Thompson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>722-05-4750</b>		17. INFORMANT <b>P.O.Box 599, Cumberland, Md</b> <b>Allegany County Infirmary records.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>Virus Pneumonia</b> DUE TO <b>Mycocarditis Chn. degenerative</b> (b) <b>Anterior Sclerosis &amp; Hypertension</b> DUE TO <b>Cerebral Apoplexy &amp; Left Hemiplegia</b> (c) <b>Old Fracture Left Clavicle</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/14/64</b> , 19__, to <b>3/10/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>3/9/66</b> , 19__, and that death occurred at <b>A. M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Lee B. Mathews, M. D.</b>		at <b>12:40 A.M.</b>			22b. DATE SIGNED <b>March 10, 1966</b>				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>March 12, 1966</b>		<b>Hillcrest Burial Park</b>		<b>Cumberland, Maryland</b>			
24. FUNERAL DIRECTOR <b>John F. Haffer</b>				ADDRESS <b>230 Baltimore Ave., Cumberland</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03103

03117

Allegany

Maryland

Allegany

Clinton

3/11/64

Under and

Route 42

Allegany County Jail

66

March 10, 1966

Clinton

Clinton

Clinton

76

12/26/1989

X

White

Male

U. S. A.

Maryland

Farmer

Noted; former

James H. Thompson

Hannah Thompson

P.O. Box 509

Clinton

Allegany County Jail

3/10/66

3/11/64

3/10/66

at 12:10 A.M.

X

X

Mr. D. H. H. H.

March 10, 1966

Clinton, Md.

Clinton, Md.

Clinton, Md.

Clinton, Md.

11



03118

## CERTIFICATE OF DEATH

03103

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>21 National High La Vale</b>	
c. LENGTH OF STAY IN lb <b>17 days</b>		d. STREET ADDRESS <b>21 National Highway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Rebecca Martz</b>		4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/20/96</b>
9. AGE (In years lost birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Issac Stonebreaker</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Katherine Runion</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Chester Rotruck, 275 Keys St Keyser WVa</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left posterior subphrenic abscess</b> 576X <b>Retropneumothorax abscess, Cause?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3 weeks</b> (b) <b>Retropneumothorax abscess, Cause?</b> (c) <b>Retropneumothorax abscess, Cause?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Equal failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> , 19 <b>66</b> , to <b>3/2</b> , 19 <b>66</b> , that (I) (we) saw the deceased alive on <b>3/1</b> , 19 <b>66</b> , and that death occurred at <b>7:05</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Weisman</b>		22b. DATE SIGNED <b>3/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Weisman</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 5, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sts Peter &amp; Paul Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md</b>	
24. FUNERAL DIRECTOR <b>John F. Hafer</b>		25a. REC'D BY REGISTRAR <b>1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02103

02103

RECEIVED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03119

03104

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>13 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>7 RACE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FORREST W. MC BEE</b>				4. DATE OF DEATH <b>MARCH 16 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 30, 1898</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>GEORGE MC BEE</b>			
14. MOTHER'S MAIDEN NAME <b>NANCY HUTZLER</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>705-07-9516</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592x Myemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Car Nephritis</b> (c) <b>Branchial Asthma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>147</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/12/66</b> to <b>3/16/66</b> , that (I) (we) last saw the deceased alive on <b>3/16/66</b> 19__, and that death occurred at <b>7:05 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>3/18/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>3/19/66</b>		<b>Methodist Cem.</b>		<b>Buck Valley Penna</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b> ADDRESS <b>Cumberland</b>				25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

03104

03119

ALLERANY

HARRY AND

ALLERANY

CUMBERLAND

13 DAYS

CUMBERLAND

7 RACE ST.

MEMORIAL HOSPITAL

MARCH 18

MC BEE

W.

FOREST

MARCH 30, 1938

MALE WHITE

WEST VIRGINIA

U.S.A.

HARRY HUTLER

GEORGE MC BEE

MEMORIAL HOSPITAL

7:05 P.M.

DR. R. J. WILLIAMS

122 S. CENTRE ST. CUMBERLAND, MD.

MAR 31 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03120					03105					
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
Allegany MARYLAND					Pa. Somerset					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b						
Cumberland				2 Days						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
Sacred Heart Hospital					Rt. # 1					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
Carl E Mc Clintock					3 5 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1/24/00		66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Auto Mechanic				Automobile		Salisbury, Pa.		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Hampton Mc Clintock					Anna Mae Bodden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFIRMANT Address			
No					202 12 1395		Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Emphysema, Severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial Asthma - Bronchiectasis								INTERVAL BETWEEN ONSET AND DEATH Years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19										
21. I certify that (I) (this hospital) attended the deceased from 3-3, 1966, to 3-5, 1966, that (I) (we) last saw the deceased alive on 3-4, 1966, and that death occurred at 4:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Calvin Y. Hadidian					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 3-5-66		
22c. PHYSICIAN'S NAME (Type) Dr. Hadidian					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8 Mar 66		23c. NAME OF CEMETERY OR CREMATORY J.O.O.F		23d. LOCATION (City, town or county) (State) Berlin, Somerset Co. Pa.			
24. FUNERAL DIRECTOR Walter A. Johnson					ADDRESS Berlin, Pa.		25a. REC'D BY REGISTRAR DATE MAR 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03121 03106											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>						d. STREET ADDRESS <b>Jackson Street</b>					
3. NAME OF DECEASED (Type or print) <b>Margaret McDonough</b>						4. DATE OF DEATH <b>March 18 19 66</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1884</b>		9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, Maryland</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Patrick Stakem</b>						14. MOTHER'S MAIDEN NAME <b>Esther Cavanaugh</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>						16. SOCIAL SECURITY NO. <b>Roy McDonough</b>					
17. INFORMANT <b>Lonaconing, Md.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> 4201 DUE TO <b>Advanced coronary insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arteriosclerosis - generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>"Son"</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>6 mos.</b> <b>years</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>March 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 17, 1966</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>H. R. Miles, Jr.</b> M.D.						22b. DATE SIGNED <b>3-18-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>H. R. MILES, JR., M.D.</b>						22d. ADDRESS <b>LONA CONING, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lonaconing, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>						25a. REC'D BY REGISTRAR <b>MAR 23 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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YOUNG, J. C. 1983. *Journal of Fish Biology* 23:1-10.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03122									
03107									
CERTIFICATE OF DEATH									
Item 8 Film G375 4/17/66 mh									
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE b. COUNTY							
Allegany		Maryland Allegany							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Frostburg		1 week		Frostburg					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Miners Hospital				148 Bowery Street					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
Harvey		A.		Miller		March		25 19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1881		84 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Building Contractor		Self Employed		Garrett County			U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Stephen C. Miller				Ellen (LAST NAME UNKNOWN)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		218-31-9101		Mrs. Harvey Miller		148 Bowery Street, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of prostate</i> DUE TO (b) <i>Secondary anemia</i> DUE TO (c) <i>Senility</i>								INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>2 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from <i>1-15-</i> , 19 <i>66</i> , to <i>3-25</i> , 19 <i>66</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>3-25</i> , 19 <i>66</i> , and that death occurred at <i>4A</i> M, from the causes and on the date stated above.									
22a. SIGNATURE				22b. DATE SIGNED					
<i>H.C. Diehl</i>				<i>3-26-66</i>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
H. C. Diehl, M.D.				39 W. Main St., Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		Mar. 27, 1966		Frostburg Mem. Park Frostburg, Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HAFER FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD		APR 4 1966		<i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G574 3/18/66 mn

CERTIFICATE OF DEATH

03108

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		c. LENGTH OF STAY IN 1b <b>52 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Railroad St.</b>		d. STREET ADDRESS <b>Railroad St.</b>	
3. NAME OF DECEASED (Type or print) <b>Raymond Montgomery</b>		4. DATE OF DEATH <b>Mar. 9 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1913</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Allegany- Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Montgomery</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Susan Beeman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Robert L. Montgomery-Barton, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>14 Hours</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 9, 1966</b> , to <b>Mar. 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar. 9, 1966</b> , and that death occurred at <b>9 P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Paul R. Wilson</b>		22b. DATE SIGNED <b>Mar. 11, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>		22d. ADDRESS <b>Piedmont, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/11/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Moscow Mills Md.</b>	
24. FUNERAL DIRECTOR <b>Ed Brul</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 1966</b>	
ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

20160

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## MARYLAND STATE DEPARTMENT OF HEALTH -

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03124 CERTIFICATE OF DEATH 03109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>11/24/65</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>				d. STREET ADDRESS <b>RFD#1, Franklin, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Regina Cordota Moran</b>		First Middle Last		4. DATE OF DEATH <b>March 19 1966</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/1894</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bookkeeper Grocery</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Daniel Moran</b>			14. MOTHER'S MAIDEN NAME <b>Bridget Gilmore</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-01-1311</b>		17. INFORMANT <b>P.O. Box 599 Cumberland, Md. Allegany County Infirmary</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x</b> <b>Hypertensive Chn. degenerative</b> DUE TO (b) <b>Cerebral Thrombosis &amp; left hemiplegia</b> DUE TO (c) <b>Hypertensive cardiac vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, Both knees</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/24/65</b> , 19__, to <b>3/19/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>3/19/66</b> , 19__, and that death occurred at <b>9 A M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Lee B. Mathews</b>				22b. DATE SIGNED <b>3/19/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M.D.</b>	
22d. ADDRESS <b>49 Greene St. Cumberland, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/22/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>		23d. LOCATION (City, town or county) (State) <b>Westernport Md.</b>	
24. FUNERAL DIRECTOR <b>El. Bral</b>				ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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03125

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN lb <b>58 years</b>		d. STREET ADDRESS <b>408 York Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>A.</b> Last <b>Nee</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1907</b>
9. AGE (In years lost birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Nee</b>		14. MOTHER'S MAIDEN NAME <b>Matilda O'Donnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes War II</b>		16. SOCIAL SECURITY NO. <b>705-09-9949</b>	
17. INFORMANT <b>Mrs. Sarah Nee, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>March 22, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Cumberland, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 25, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25. REC'D BY REGISTRAR <b>MAR 24 1966</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*[Faint handwritten signature or text]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03126

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN b. <b>3/21/66</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>213 Fulton Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Neff</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/1866</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Merrick A. Stoner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anna Linn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-18-1046</b>	
17. INFORMANT <b>P.O. Box 599, Allegany County Infirmary records.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>Myocarditis, chr. degenerative</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>decompensating, Sicile</b> (c) <b>Arterio sclerosis</b> (d) <b>Diabetes Mellitus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/21/66</b> , 19__, to <b>3/24/66</b> 19__, that (I) (we) last saw the deceased alive on <b>3/23/66</b> 19__, and that death occurred at <b>A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee B. Mathews</b>		22b. DATE SIGNED <b>3/24/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MARCH 26, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		25. RECORD BY REGISTRAR <b>MAR 30 1966</b>	

03111

03120

Allegany

Maryland

Allegany

Cumberland

3/27/66

Cumberland

SIS Fulton Street

Also any County Jail

03

March 27

1966

1966

1966

03

3/27/66

X

White

Female

U. S. A.

penitentiary

Housewife

Harry Anna Mann

Mortimer A. Stoner

Cumberland, Md.

P.O. Box 242

3/27-10/66

3/27/66

3/27/66

3/27/66

at 12:30 A.M.

3/27/66

Cumberland, Md.

19 Greene St.

Joe B. Johnson, M. D.

3/27/66



03127

## CERTIFICATE OF DEATH

03112

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>1803 BEDFORD ST.</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM JOSEPH NEUBEISER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-83</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Market (Meat)</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Neubeiser</b>		14. MOTHER'S MAIDEN NAME <b>Mary Knierheim</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-8022</b>	
17. INFORMANT <b>Mr. Joseph R. Neubeiser</b>		Address <b>1803 Bedford St. Cumb., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS UNDERLYING: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Carcinoma of the Prostate Gland.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>20 yr.</b> <b>4 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Generalized arteriosclerosis-</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>None</b> 19 <b>66</b> p.m. <b>None</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 16, 1964</b> to <b>March 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1966</b> , and that death occurred at <b>9:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Hallinan</b>		22b. DATE SIGNED <b>3-9-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. HALLINAN</b>		22d. ADDRESS <b>140 BEDFORD ST. CUMBERLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>MAR 11 1966</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03113

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1952

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1952-1953

General Information

General Information

General Information

General Information

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FOR STATE  
HEALTH DEPT.

03128 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03113

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> <b>01-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart--DOA</b>				d. STREET ADDRESS <b>1314 Virginia Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>L.</b> Last <b>Nines</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1915</b> <b>50</b> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman -Rest. Oper.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Davis W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Ezra C. Nines</b>				14. MOTHER'S MAIDEN NAME <b>Ella White</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>298-09-3713</b>		17. INFORMANT <b>Mrs. Thelma Nines, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia, Bilateral</b> 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				22. DATE SIGNED M.D. <b>March 11, 1966</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, Maryland</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 13, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03113

03113

RECEIVED

1966

John F. Kennedy

X

1966

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1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03129					CERTIFICATE OF DEATH					03114				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYIA ND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>					c. LENGTH OF STAY IN 1b <b>4 DAYS</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>					d. STREET ADDRESS <b>27 FIRST STREET</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>PASSARELLI</b> Last <b>PASSARELLI</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>19 66</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 28, 1895</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED MERCHANT</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>					11. BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>MICHAEL PASSARELLI</b>					14. MOTHER'S MAIDEN NAME <b>ROSINA ROSANOVA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW 1</b>					16. SOCIAL SECURITY NO. <b>212-32-8042</b>					17. INFORMANT <b>MRS. SUSAN PASSARELLI, FROSTBURG, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crownary occlusion</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema &amp; silicosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> , 19 <b>66</b> to <b>3/17</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>3/17</b> , 19 <b>66</b> and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>John B. Davis, M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>2/18/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>JOHN. B. DAVIS, M. D.</b>					22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>MAR. 21 '66</b>					23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>				
23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>														
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>					25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

081180

081180

MAR 21 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>RT.#2, BALTIMORE PIKE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>HOWARD</b>			First <b>HOWARD</b>			Middle <b>PERRIN</b>			Last <b>PERRIN</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>14</b> Year <b>19 66</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 29, 1884</b>			9. AGE (in years last birthday) <b>82</b>		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>15</b>		11. IF UNDER 24 HRS. Hours <b>14</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter - Self Employed</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Employed</b>			11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>FRANKLIN PERRIN</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH FELTON</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-10-4560</b>			17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>3-20-66, 4:15 P.M. to 3-14, 1966</b> , that (I) (we) last saw the deceased alive on <b>3-14-1966</b> , and that death occurred at <b>3-14-1966</b> , M, from the causes and on the date stated above.														
22a. SIGNATURE <b>Wm. F. Williams</b>						22b. DATE SIGNED <b>3-15-66</b>			22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>			22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/17/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City, town or county) <b>Cumberland Maryland</b>					
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>						25a. REC'D BY REGISTRAR <b>MAR 18 1966</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

03115

03170

6

ALLEGANY

WARRAND

ALLEGANY

CUMBERLAND

4 DAYS

CUMBERLAND

RT. 12, BALTIMORE PKT

MEMORIAL HOSPITAL

MARCH 15 1936

PERRIN

HOWARD

FEB. 22, 1936

MALE WHITE

U.S.A.

PENNA.

ELIZABETH PERRIN

FRANKLIN PERRIN

MEMORIAL HOSPITAL

*Franklin Perrin*  
*Elizabeth Perrin*

5:15 P.M.

122 S. CENTRE ST. CUMBERLAND, MD.

DR. J. J. WILLIAMS

MAR 18 1936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

03131

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03116

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>1/18/1965</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>			d. STREET ADDRESS <b>804 Washington Street</b>		
3. NAME OF DECEASED (Type or print) <b>Susanna Allison Peters</b>			4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/1886</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Elvin E. Schartel</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Allison</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-32-8304</b>		
17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> <b>Myocarditis, chr. degenerative</b> DUE TO <b>(2) arterio sclerosis, general + cerebral</b> DUE TO <b>(3) cerebral apoplexy, Rt. Hemiplegia</b> DUE TO <b>(4) atherosclerosis of coronary artery + gangrene Rt. hand (apoplexy)</b> DUE TO <b>(5) Parkinson's Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/18/65</b> , 19__, to <b>3/25/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>3/24/66</b> , 19__, and that death occurred at <b>A</b> M., from the causes and on the date stated above.					
22a. SIGNATURE <b>Lee B. Mathews</b>			22b. DATE SIGNED <b>3/25/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>			22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hickwood Burial Ph. Cumberland Md</b>	
23d. LOCATION (City, town or county)		(State)			
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>			25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

03134

03134

Allegany

Allegany

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Allegany

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Allegany

Allegany County Infirmary

Allegany County Infirmary

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1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY CAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03117

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>75 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Front Street</b>				d. STREET ADDRESS <b>Front Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ESTELLA</b> Last <b>PHILLIPS</b>				4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/9/1890</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>David Mackay</b>				14. MOTHER'S MAIDEN NAME <b>Rosa May Allen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Patrick McDonough, Lonaconing, MD.</b> (Daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>CORONARY SCLEROSIS</b> (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b></b> e.m. <b></b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Cumberland, MD.</b> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>				ADDRESS <b>Lonaconing, MD.</b>		24a. REC'D BY REGISTRAR <b>MAR 23 1966</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03117

03118

RECEIVED  
JAN 10 1962  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY FOR  
FOREIGN AFFAIRS  
MEMORANDUM FOR THE ASSISTANT SECRETARY FOR  
FOREIGN AFFAIRS  
SUBJECT: [Illegible]  
DATE: [Illegible]  
FROM: [Illegible]  
TO: [Illegible]  
[The remainder of the document contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. Some words like "United States" and "Department of Agriculture" are faintly visible.]



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03133

03118

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Evelyn Nisbit Piper</b>				4. DATE OF DEATH Month Day Year <b>3 2 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/26/07</b>	
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Millard Fowler</b>				14. MOTHER'S MAIDEN NAME <b>Louise Kemp</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>338-12-5490</b>		17. INFORMANT Address <b>Chart Simon F. Piper, Oldtown, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>1 year</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-28</b> , 19 <b>66</b> , to <b>3-2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-1</b> , 19 <b>66</b> , and that death occurred at <b>6-1</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Lem Brings</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. Brings</b>				22d. ADDRESS <b>57 Greene Street</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Methodist Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Oldtown, Allegany Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John J. Hafer 230 Balto Ave., Cumberland, Md</b>				25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03134 CERTIFICATE OF DEATH					03119				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>MINERAL</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>25 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WILEY FORD</b> 85-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VIRGINIA</b>		First Middle Last <b>BELLE POWELL</b>		4. DATE OF DEATH Month Day Year <b>MARCH 1 19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-29-1883</b>		9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA Mo. U. S. A.</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>GEORGE SAVILLE</b>					14. MOTHER'S MAIDEN NAME <b>ANNA SHANHOLTZ</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest - Aorta</b> <b>4330</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3rd Degree Heart Block - Fibrillate</b> (c) <b>Arteriosclerotic Aortic Valve Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetic Mellitus</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19, to <b>March</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>March 1</b> , 19 <b>66</b> , and that death occurred at <b>3:50 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/2/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>				22d. ADDRESS <b>133 VIRGINIA AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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MINERAL

VA.

WILEY ROAD

22 DAYS

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

VIRGINIA

REVELL

MARCH

3-29-1883

X

FEMALE WHITE

WEST VIRGINIA

NEW YORK

CONNECTICUT

ANNA SHADDOCK

GEORGE SAVILLE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. E. O. HINCHLINTON 133 VIRGINIA AVE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03135					03120						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>ALLEGANY</b>					e. STATE <b>W. VIRGINIA</b> b. COUNTY <b>HAMPSHIRE</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PAW PAW</b>						
c. LENGTH OF STAY in 1b <b>35 DAYS</b>					d. STREET ADDRESS <b>BOX 245</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First <b>JAMES</b>		Middle <b>H.</b>		Last <b>ROUZEE</b>		4. DATE OF DEATH		
									Month <b>MARCH</b> Day <b>11</b> , Year <b>19 66</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-14-1892</b>		9. AGE (in years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>RIVERTON, W. VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GEORGE ROUZEE</b>						14. MOTHER'S MAIDEN NAME <b>MARY E. FISHER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Thrombosis</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Prostatitis Suggestion of Malignancy</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6-4-1965</b> to <b>3-11-1966</b> , that (I) (we) last saw the deceased alive on <b>3-11-1966</b> and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <b>W. F. Williams</b>				22b. DATE SIGNED <b>3-12-66</b>				22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>			
22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>#3/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Camp Hill Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Paw Paw, W. Va.</b>	
24. FUNERAL DIRECTOR <b>Johnson Funeral Homes Berkeley Spgs.</b>				25a. REC'D BY REGISTRAR <b>W. F. S. 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03130

03132

HAMPSHIRE

N. VIRGINIA

ALLEGANY

RAW FAW

32 DAYS

CUMBERLAND

BOX 202

MEMORIAL HOSPITAL

MARCH 11, 1968

HOUSE

JAMES

8-14-1967

WHITE

W. VA.

W. E. FISHER

GEORGE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

1:00 P.M.

20

132 S. CLAY ST., CUMBERLAND, MD.

DR. W. F. WILLIAMS

Lawson, W. Va.

Camo Hill, Conn.

W. Va.

W. Va.

Johnson General Hospital Berkeley, Calif.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03136

03121

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>				c. LENGTH OF STAY IN 1b <u>11-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D. O. A. Sacred Heart Hosp.</u>				d. STREET ADDRESS <u>212 Decatur St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Wilson</u> Last <u>Schoonover</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1939</u>	9. AGE (In years last birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u>26</u> Min. <u>26</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1De. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		1Db. KIND OF BUSINESS OR INDUSTRY <u>Auto Service Station</u>		11. BIRTHPLACE (State or foreign country) <u>Elkins, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Della G. Schoonover</u>				14. MOTHER'S MAIDEN NAME <u>Dora E. Louk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes,</u>		16. SOCIAL SECURITY NO. <u>1956-1958</u>		17. INFORMANT <u>Mrs. Mary J. Schoonover</u> Address <u>212 Decatur St. Cumb. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8254</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CRUSHED SKULL, FRACTURED NECK</u> (c) <u>(PASSENGER IN SINGLE AUTO ACCIDENT)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>PASSENGER IN SINGLE AUTO ACCIDENT</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11:10</u> p.m. <u>March 20</u> <u>1966</u>		2Dd. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT. 28, 2 mile south, Wiley Ford, Mineral, W. Va.</u>		2Df. (City or town) (County) (State) <u>Wiley Ford, Mineral, W. Va.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				DATE SIGNED <u>March 20, 1966</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 28 1966</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1988

58136

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11:27 March 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
031137 CERTIFICATE OF DEATH 03122									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>38 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>202 SPRINGDALE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>GLADYS</b> Middle <b>L.</b> Last <b>SCOTT</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>19 66</b>				
5. SEX <b>WHITE</b>		6. COLOR OR RACE <b>FEMALE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>905 MAY 18, 1906</b>		9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			11. BIRTHPLACE (County & State, or foreign country) <b>ALLEG. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ULYSSES MC KENZIE</b>					14. MOTHER'S MAIDEN NAME <b>ORA HINES</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon with</b> <b>1538</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>metastasis liver and lungs and</b> DUE TO (c) <b>terminal cachexia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 yr +</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 1966, to <b>March 19</b> , 1966, that (I) (we) last saw the deceased alive on <b>March 19</b> , 1966, and that death occurred at <b>1057 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Wylie M Faw Jr</b>					22b. DATE SIGNED <b>March 19 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. WYLIE M. FAW JR.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-22-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		

03128

03128

WAGYLAND

WAGYLAND

CUMBERLAND

CUMBERLAND

38 DAYS

MEMORIAL HOSPITAL

103 SPRINGDALE ST.

68

19

WAGON

STREET

L.

GLAYS

MAY 18, 1968

WHITE, RONALD

ALLEG. CO. RD.

U.S.A.

ORD NINES

IN VESSEL MC KENZIE

MEMORIAL HOSPITAL

133 S. CENTRE ST. CHMS. MO.

DR. WYLLIE H. FOWLER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>11/3/65</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>						d. STREET ADDRESS <b>121 N. Allegany St.</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Marvin Shaw</b>						4. DATE OF DEATH Month Day Year <b>March 17 19 66</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/12/1881</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Perry Weimer</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Zebach</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Myocarditis, aka degenerative</b> <b>4221</b> DUE TO <b>E Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(2) Anterior scierosis, general + cerebral</b> DUE TO <b>(3) Hardened cerebral arteries, Parkinson's Disease</b> (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/3/65</b> 19 <b>65</b> , to <b>3/16/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/16/66</b> 19 <b>66</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee B. Mathews, M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/17/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M.D.</b>						22d. ADDRESS <b>49 Greene St. Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>				25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

02183

02183

Allegany

Maryland

Allegany

Combedland

M/155

Combedland

Allegany Co.

Allegany County Jail

X

17

17

17

17

17

17

17/151

X

17

17

Allegany Maryland

Allegany

Allegany

Allegany

Allegany County Jail

Allegany

17/151

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Allegany Co. Maryland

Allegany Co. Maryland

17/151

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MAR 2 1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03139 CERTIFICATE OF DEATH 03124									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>214 SOUTH LEE STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>MAY</b> Last <b>SHORT</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA Mineral Co.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH PYLES</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH DOWDEN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ernest Evans</b> Address <b>214 South Lee St - CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Postural Myocardial Infarction</b> <b>4201</b> DUE TO <b>Arteriosclerotic Coroner's Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dilated Myocardium</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 Day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>5/10/66</b> , 19 to <b>1966</b> , 19, that (I) <del>two</del> last saw the deceased alive on <b>3/10/66</b> , 19, and that death occurred at <b>5:27</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					22b. DATE SIGNED <b>3/12/66</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>					22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George</b> <b>Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>15 MAR 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

03183

03183

ALLEGANY

MARYLAND

ALLEGANY

2 DAYS

CHINESE AND

214 SOUTH LEE STREET

MEMORIAL HOSPITAL

HARBO

SHORT

MAY

ADA

EX 2-2-1882

X

FEMALE WHITE

CO.

WEST VIRGINIA

CO. 10

HOSPITAL

ELIZABETH BOWDEN

JOSEPH BYLES

MEMORIAL HOSPITAL - 214 SOUTH LEE STREET, HARBO

HAND

*Handwritten notes and signatures, including "Miss Mary" and "Miss Elizabeth Bowden".*

*Handwritten signature: "Miss Mary"*

*Handwritten notes and dates: "3/2/22", "3/2/22", "3/2/22".*

*Handwritten notes and signatures, including "Miss Mary" and "Miss Elizabeth Bowden".*

103 VIRGINIA AVE., SUMMERLAND, MD

DR. C. O. KIMMELMINTZ

MAR 12 1922

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03140					03125				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>35 BEALL STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>SLINGLOFF</b> Last <b>SLINGLOFF</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>19 66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 3, 1898</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESSER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM SLINGLOFF</b>					14. MOTHER'S MAIDEN NAME <b>MARY WILSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-12-8152</b>		17. INFORMANT <b>MISS FRED A SLINGLOFF, FROSTBURG, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio-sclerotic heart disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Secondary anemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 1/2 yrs</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>11-10</b> , 19 <b>65</b> , to <b>3-10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-10</b> , 19 <b>66</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>H. C. Diehl</b> 22c. PHYSICIAN'S NAME (Type) <b>H. C. DIEHL, M. D.</b>					22b. DATE SIGNED <b>3/11/66</b> 22d. ADDRESS <b>W. MAIN ST., FROSTBURG, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FR'G. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>					25. REGISTRAR'S SIGNATURE <b>Charles Judge</b> DATE <b>MAR 14 1966</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

03126

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	c. LENGTH OF STAY IN 1b <b>30 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FLINTSTONE,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>STAR ROUTE</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>--</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 15, 1892</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR: Months <b>01</b> Days <b>1</b> IF UNDER 24 HRS. Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry Business</b>	11. BIRTHPLACE (State or foreign country) <b>BEDFORD CO. PA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Isaac Smith</b>	
14. MOTHER'S MAIDEN NAME <b>Sophia Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	
16. SOCIAL SECURITY NO. <b>195-22-1395</b>		17. INFORMANT <b>Mrs. Marie Mauk, Star Rt. Flintstone, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia + hyperpyrexia</b> <b>0534</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Infection</b> DUE TO (c) <b>Unknown cause</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac Failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 12, 1966</b> to <b>March 12, 1966</b> , that I last saw the deceased alive on <b>March 12, 1966</b> , and that death occurred at <b>6:37 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>412 N. Mechanic St. Cumb. Md.</b> DATE SIGNED <b>3/14/66</b>			
ACTUAL SIGNATURE <b>Walter N. Himmler</b>		PHYSICIAN'S NAME (Type) <b>DR. WALTER N. HIMMLER</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Artemas, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 17 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

0118

STATE OF NEW YORK - ALBANY, 19

## CERTIFICATE OF DEATH

DECEASED

PL. 11111111

STATE ROUTE

MARCH 19 1907

DEC. 17, 1907

BEDFORD CO. PA.

STATE

HOSPITAL

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DR. WALTER W. HILTON

HIT. N. MEDICAL ST. COM. NO.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03142					03127				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN, PA.</b> d. STREET ADDRESS <b>RT.#1, BOX 4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>J.</b> Last <b>SNYDER</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1966</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 7, 1878</b>		9. AGE (in years last birthday) <b>88</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>			11. BIRTHPLACE (County & State, or foreign country) <b>EVERETT, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur A. Snyder</b>					14. MOTHER'S MAIDEN NAME <b>SUSANNA WAKEFOOSE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>705-03-6308</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardia - Acute Koronary Failure</b> <b>6000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pyelonephritis</b> (c) <b>Chronic Pyelonephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardio-Vascular disease</b>									
19. INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 yrs.</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6 Mar 66 6:30 P.M.</b> <b>9 Mar</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9 Mar</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>James B. Stegmaier</b>									
22b. DATE SIGNED <b>10 Mar. 66</b>									
22c. PHYSICIAN'S NAME (Type) <b>DR. JAMES G. STEGMAIER</b>					22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Mar. 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hyndman, Bedford Co. Pa.</b>		
24. FUNERAL DIRECTOR <b>Harvey V. Feigler</b> ADDRESS <b>Hyndman, Pa.</b>					25a. REC'D BY REGISTRAR <b>MAR 16 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

03187

03187

RECORD

PENNSYLVANIA

ALLEGANY

HYNDMAN, PA.

3 DAYS

CUMBERLAND

RT. 1, BOX 4

MEMORIAL HOSPITAL

MARCH 9 1966

J. SNYDER

FRANCIS

MARCH 7, 1938 88

MALE WHITE

U.S.A.

EVERETT, PA.

SUSANNA

MEMORIAL HOSPITAL

6:30 P.M.

DR. JAMES H. STEGMAIER

132 S. CENTRE ST.

CUMBERLAND, MD

MAR 10 1966

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03143

03128

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>408 Park Street</b>	
3. NAME OF DECEASED (Type or print) <b>Wilbert</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/7/13</b>
9. AGE (In years last birthday) yrs. <b>52</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroader (switch tender)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Bereton, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>*HARRISONBURG, PA.</b>	
13. FATHER'S NAME <b>Ransom Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>Patient's chart</b>		Address <b>Mrs. Louis Lawton</b> <b>5104, 70th Ave</b> <b>Hyattsville Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cirrhosis of the liver</b> DUE TO (c) <b>approx 3 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/11/66</b> , 19 <b>66</b> , to <b>3/5</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>3/5</b> , 19 <b>66</b> , and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. Spiggle</b>		22b. DATE SIGNED <b>3/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Spiggle</b>		22d. ADDRESS <b>126 N Smallwood, Cumberland Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/9/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tomahawk Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hedgesville, West Virginia</b>
24. FUNERAL DIRECTOR <b>John F. Hofer</b>		25a. REC'D BY REGISTRAR <b>230 Baltimore Avenue</b> <b>Cumberland, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 8 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the deceased remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03144 CERTIFICATE OF DEATH 03129									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>43 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>132 BEDFORD STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>CHESTER</b> Middle <b>D.</b> Last <b>SOWERS</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-13-1898</b>		9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months <b>01</b> Days <b>1</b> IF UNDER 24 HRS: Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Pharmacist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES J. SOWERS</b>					14. MOTHER'S MAIDEN NAME <b>MARGARET J. KNOTT</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis &amp; hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Embolism - Perforation of Bladder</b>								INTERVAL BETWEEN ONSET AND DEATH <b>45d</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 <b>3-11</b> to <b>3-11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-10</b> 19 <b>66</b> and that death occurred at <b>7:35 A.M.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>William P. James</b>									
22b. DATE SIGNED <b>3/14/66</b>									
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>									
22d. ADDRESS <b>441 N. CENTRE ST., CUMBERLAND, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
23b. DATE THEREOF <b>3/14/66</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cema</b>									
23d. LOCATION (City, town or county) (State) <b>Cumberland MD</b>									
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb MD</b>									
25a. REC'D BY REGISTRAR <b>Charles Judge</b>									
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									
DATE <b>MAR 18 1966</b>									

03150

03150

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

43 DAYS

CUMBERLAND

123 BEDFORD STREET

MEMORIAL HOSPITAL

MARCH 11

SOWERS

D.

CHESTER

67

2-13-1893

WHITE

MALE

M. S. A.

CUMBERLAND, MD.

CHARLES J. SOWERS

MARGARET J. KNOTT

MEMORIAL HOSPITAL - CUMBERLAND, MD.

7:32 A.M.

DR. WILLIAM P. JAMES

441 N. CENTRE ST., CUMBERLAND, MD.

MAY 12 1893



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>507 EAST OLDTOWN ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>WILLIAM H. STALLINGS</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1966</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-28-1894</b>		9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR: Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED -Maintenance Dept. Store</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NATHAN STALLINGS</b>					14. MOTHER'S MAIDEN NAME <b>ANNA Q. TWIGG</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>War I</b>			16. SOCIAL SECURITY NO. <b>218-24-7875</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> <b>4221</b> DUE TO <b>Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Myocarditis (interosseal)</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>4 yrs</b> <b>7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> to <b>Mar 5, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar. 5, 1966</b> , and that death occurred at <b>11:00 P.M.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/6/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>					22d. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

03180

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ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

CUMBERLAND

2 DAYS

MEMORIAL HOSPITAL

507 EAST GLOTTON ROAD

WILLIAM H. STALLINGS

WILLIAM H. STALLINGS

MARCH 2, 1934

MALE WHITE

9-28-1894

VI

RETIRED

CUMBERLAND, MD.

U.S.A.

NATHAN STALLINGS

ANN O. TWIG

MEMORIAL HOSPITAL - CUMBERLAND, MD.

*Handwritten signature and notes*

11:00 P.M.

DR. CLAY F. BURRETT

230 VERNON AVE., CUMBERLAND, MD.

MAR 10 1934

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03146

03131

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ellerslie Md.</b>				c. LENGTH OF STAY IN 1b <b>65 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ellerslie Md.</b>				e. STREET ADDRESS <b>Ellerslie Md.</b>			
3. NAME OF DECEASED (Type or print) <b>Hugh Stevenson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19 1882</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>01</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Judge</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Judge Of Court</b>		11. BIRTHPLACE (State or foreign country) <b>Perceton Scotland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Gavin Stevenson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Myrtle Stevenson Ellerslie Md.</b>		17. INFORMANT <b>Janet Hymers Stevenson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized</b> 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Pancreas</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				22. DATE SIGNED <b>March 7, 1966</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumberland Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>?</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D. O.A. Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before edimission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>742 Baker St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patty Lorraine Tabler</b>		4. DATE OF DEATH Month Day Year <b>March 20 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1936</b>
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter Rummer</b>	
14. MOTHER'S MAIDEN NAME <b>Beulah Liller</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Beulah Rummer, Wiley Ford, W. Va. - Mother</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull, Crushed Chest</b> 8254 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>(Automobile Accident)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Driver in Single Car Accident</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>11:10 p.m. March 20 19 66</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 28 2 Mile South Wiley Ford, Mineral, W. Va.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 20, 1966</b> DATE SIGNED Address (Street, city, town, or county) <b>Cumberland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 24, 1966</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 22 1966</b> 24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

SEI30



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03148					03133				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>476 WILLIAMS ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY Columbus THOMPSON Sr.</b>			4. DATE OF DEATH Month Day Year <b>MARCH 21, 1966</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-10-1896</b>		9. AGE (In years last birthday) <b>69</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Rwy.</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>KENNESAW, W. VA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>JOHN THOMPSON</b>				14. MOTHER'S MAIDEN NAME <b>DENIZA STERMS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mrs. Hester B. Thompson</b> Address <b>476 Williams St. MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>undig</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumbersville, W. Va.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/19/66</b> , 19 to <b>3/21/66</b> , 19, that (I) (we) last saw the deceased alive on <b>3/20/66</b> , 19, and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.								22b. DATE SIGNED <b>3/22/66</b>	
22a. SIGNATURE <b>J. Williams</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Primitive Baptist Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Monrose, W. Va.</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

03103

03103

WILLIAM

MARYLAND

ALLEGANY

CUMBERLAND

11 DAYS

CUMBERLAND

470 WILLIAMS ST.

MEMORIAL HOSPITAL

7

WILLIAM

THOMPSON

HARRY

11-10-1933

MALE WHITE

U. S. A.

KEENE, W. VA.

DEWITT STERNS

JOHN THOMPSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

1:00 PM

122 S. CENTRE ST.

DR. R. J. WILLIAMS

WILLIAM

MAR 21 1933

## CERTIFICATE OF DEATH

03134

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 1/2 HRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>TRACY</b> Last <b>TRACY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>29</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years last birthday) <b>58</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HARRY HILLEARY</b>		14. MOTHER'S MAIDEN NAME <b>ELSA KELLY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 16 5724</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Congestive Heart Failure - Recurrent - Ant</b> DUE TO <b>Chronic Myocarditis</b> (b) <b>Dielectric - Anteroseptal Bundle Branch Block.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 Hours.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Inter capillary Renal Sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 19 66</b> to <b>March 19 66</b> , that (I) (we) last saw the deceased after an <b>March 28 19 66</b> , and that death occurred at <b>4:15 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Dr. G. O. Kummelwright</b>		22b. DATE SIGNED <b>3/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. KUMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 31, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Winchester Va</b>
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		25a. REC'D BY REGISTRAR <b>APR 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03163

THREMBALL ST

03163

ALLEGANY

MARY AND

ALLEGANY

CUMBERLAND

CUMBERLAND

MEMORIAL HOSPITAL

1905 HOLLAND ST.

CATHERINE

TRACY

MARCH 29

TERRELL WHITE

8-27-1907

HARRISBURG

ON HIGH

CUMBERLAND, W.

HARRY KELLY

ELSA KELLY

NO. 10 E. 2ND

MEMORIAL HOSPITAL, CUMBERLAND, W.

123 VIRGINIA AVE.

DR. J. C. FIMMELWORTH

PAID BY THE HONORABLE SECRETARY

PAID BY

CUMBERLAND, MARY

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

03150

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G375 4/4/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03135

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland ROUTE 5,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <del>XXXXXX</del> <b>Sacred Heart Hospital D.O.A.</b>				d. STREET ADDRESS <b>4 Westwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nicholas</b> Middle <b>D</b> Last <b>Vlachos</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-18-1919</b>	
9. AGE (In years) <b>47</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPT. PROPOSAL DEPT.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ABL</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>NICHOLAS P. VL ACHOS</b>			
14. MOTHER'S MAIDEN NAME <b>MARY DAILEY</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW 2</b>			
16. SOCIAL SECURITY NO. <b>149 03 9215</b>				17. INFORMANT <b>EDNA H. VLACHOS, ROUTE 5, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>March 26, 1966</b>			
Address (Street, city, town, or county) <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>MARCH 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREMATORY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

08132

08132

1962

1962

1962

1962

1962

1962



03151

## CERTIFICATE OF DEATH

03136

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>1 Day</b>		d. STREET ADDRESS <b># 625 Fairview Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>White</b>		4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-7-86</b>
9. AGE (In years lost birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months <b>22</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laundry Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND (Allegany Co)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George White</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Hoenicka</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-9301A</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cerebral Vascular Accident</b> (c) <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>66</b> to <b>3/22</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>3/22</b> , 19 <b>66</b> , and that death occurred at <b>4:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Leo H. Ley</b>		22b. DATE SIGNED <b>3/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY</b>		22d. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
ADDRESS <b>Cumberland Maryland 21502</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in day event, within 72 hours after death.

36150

22130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their purpose remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>48 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>AVE. M. POTOMAC PARK</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>LOWELL ELAINE WIDMYER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>1966</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 17, 1920</b>		9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Profession</b>				11. BIRTHPLACE (County & State, or foreign country) <b>DOUBS, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ROBERT H. BARTLETT</b>						14. MOTHER'S MAIDEN NAME <b>GRACE E. HOY</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>226-36-6135</b>				17. INFORMANT <b>Rev. George S. Widmyer</b> Address <b>Ave M. Potomac Park</b>				18. CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Ovary</b> 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Primary site Colo</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ca of Colon resected 1960</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>2/10/66</b> , 19 <b>66</b> , to <b>3/30</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/29</b> , 19 <b>66</b> , and that death occurred on <b>10:48 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>S.G. WEISMAN</b> M.D.						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/1/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>S.G. WEISMAN</b>						22d. ADDRESS <b>59 GREENE ST., CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greeneway Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Berkeley Springs, W. Va.</b>					
24. FUNERAL DIRECTOR <b>H. Wayne George</b> <b>Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>APR 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

00135

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

LOWELL

FEMALE WHITE

ROBERT H. HAZLETT

280-32-210

GRACE E. HOY

BOURB, MD.

MARCH 17, 1920

WIMMER

AVE. M. POTOMAC PARK

CUMBERLAND

MARYLAND

ALLEGANY

00135

S. J. WEISMAN

50 COCHRAN ST., CUMBERLAND, MD.

APR 2 1926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

1 (M)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03153					03138				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Allegany</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2-10-66</b>			d. STREET ADDRESS <b>804 Greene St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Geraldine Rose Wilson</b>			4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-14-1886</b>		9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Francis Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Burnett</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>213-22-3893A</b>		17. INFORMANT <b>P.O. Box 599 Cumberland, Md. Allegany County Infirmary</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <i>Arteriosclerosis, cardiac Vascular disease &amp; Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> <i>disease &amp; Hypertension</i> <b>DUE TO</b> <i>"Heart Stroke" (no palpitations)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2-10-66</b> , 19, to <b>3-14-66</b> , 19, that (I) (we) last saw the deceased alive on <b>3-14-66</b> , 19, and that death occurred <b>5:00</b> A.M., from the causes and on the date stated above.									
22a. SIGNATURE <i>Lee B. Mathews</i>			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M.D.</b>				
22d. ADDRESS <b>49 Greene St. Cumberland, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/17/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Pleasant Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Rt 2 Maryland</b>		
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>			ADDRESS <b>Cumberland Maryland 21502</b>		25a. REG'D BY REGISTRAR <b>MAR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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02138

Allegany

Allegany

Allegany

2-10-66 Cumberland

2-10-66 Cumberland

804 Monroe St.

Allegany County Jail

12-66

March

Wilson

Boyd

Reverend

2-11-1966

Female White

Allegany Maryland U.S.A.

Housewife

Mr. and Mrs.

Paula Francis Wilson

Box 293 Cumberland, Md.

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

2-11-66

2-10-66

2-11-66

2:10 A

2-11-66

Box 293 Cumberland, Md.

Mr. and Mrs.

Box 293 Cumberland, Md.

Mr. and Mrs.

Allegany County Jail



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 1 (M)  
FOR STATE  
HEALTH DEPT.

03154

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03139

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN MD <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westernport</b> d. STREET ADDRESS <b>Route 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Austin Wilt</b>		4. DATE OF DEATH <b>Mar. 14 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1942</b>
9. AGE (In years last birthday) <b>23 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zedick Wilt</b>		14. MOTHER'S MAIDEN NAME <b>Alice Broadwater</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-42-4598</b>	
17. INFORMANT <b>Delores Wilt-Westernport, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b> <b>8254</b> DUE TO <b>SKULL FRACTURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>77 hours</b> <b>77 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:30 a.m. Mar. 11 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 220, 2 Mile South Cresaptown, Alleg. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		22. DATE SIGNED <b>March 14, 1966</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town or county) (State) <b>Westernport, Md.</b>	
24. FUNERAL DIRECTOR <b>Ed Boral</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1966</b>	
ADDRESS <b>Westernport, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Figure 6

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John B. Goodenow

*(continued)*

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Send ☐ Details ☐ Contact

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Robert L. Taylor

420

25315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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<div>1</div> <div>M</div> <div>03155</div> <div>03140</div>											
<div>1</div> <div>M</div> <div>03155</div> <div>03140</div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>18 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SYLVAN RETREAT</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>619 N. MECHANIC STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>CHRISTIAN GROVER CLEVELAND ZINK</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>MARCH 2 1966</b>					
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JULY 29, 1906</b>		<b>9. AGE</b> (In years last birthday) <b>79</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Boilermaker - McKaigs Foundry</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>ALLEGANY, MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>GEORGE ZINK</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET KNIPP</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>214-05-8816</b>		<b>17. INFORMANT</b> <b>Mrs. Pauline Moyer</b>		<b>Address</b> <b>49 N. Mechanic St</b> <b>Cumberland, Md</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Myocarditis chr. degenerative Senile</b> <b>150X</b> <b>DUPLICATE</b> <b>(b) Arteriosclerosis</b> <b>(c) Carcinoma of Esophagus</b> <b>(d) 17:11 Senile, psychotic</b> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>SEPT. 4, 1964</b> <b>to</b> <b>MARCH 2, 1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>MARCH 1, 1966</b> , <b>and that death occurred at</b> <b>5 A.M.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>L. B. MATHEWS, M.D.</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b>						<b>22d. ADDRESS</b> <b>49 GREENE ST., CUMBERLAND, MARYLAND</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/4/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Memorial Park</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Cumberland Rt 3 Maryland</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ruth E. Silcox</b>						<b>ADDRESS</b> <b>Cumberland Maryland 21502</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 7 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>	

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